DEATH REPORTING AND

INVESTIGATION SUMMARY OF

STATUTORILY REPORTABLE DEATHS

IN 2001

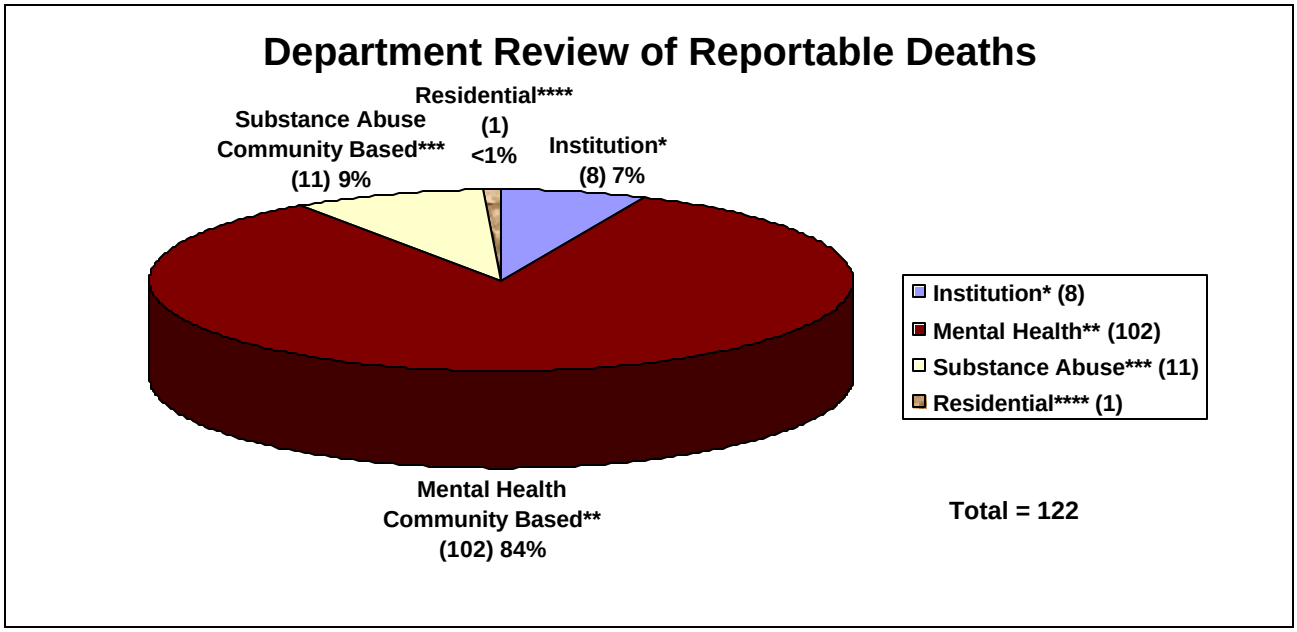
Division of Supportive Living
Department of Health and Family Services

December 2002

THE 2001 WISCONSIN STATUTORILY REPORTABLE DEATH REVIEW SUMMARY

The following summary report and graphics reflects data collected on reportable deaths under Sections 46.80(5)(a), 50.035(5), and 51,64, Wis. Stats. from January 1, 2001 through December 31, 2001. Overall, a total of 178 client/patient deaths were reported to the Department by state-certified and/or licensed programs/facilities in the treatment fields of mental health, substance abuse, developmental disabilities and long-term care. Of these, 122 deaths were determined to be reportable under the statutory requirements.

Graphic 1 shows the total numbers of reportable deaths (122) by program/facility type.



* Mental Health Inpatient Hospitals, Nursing Homes and Child Care Institutions
** Mental Health Outpatient, Community Support Programs, Mental Health Crisis Programs
*** AODA Inpatient, Outpatient, Methadone Programs, Day Treatment Programs
**** Community Based Residential Facilities

Graphic 2 shows the gender and age ranges for all reportable deaths (84).

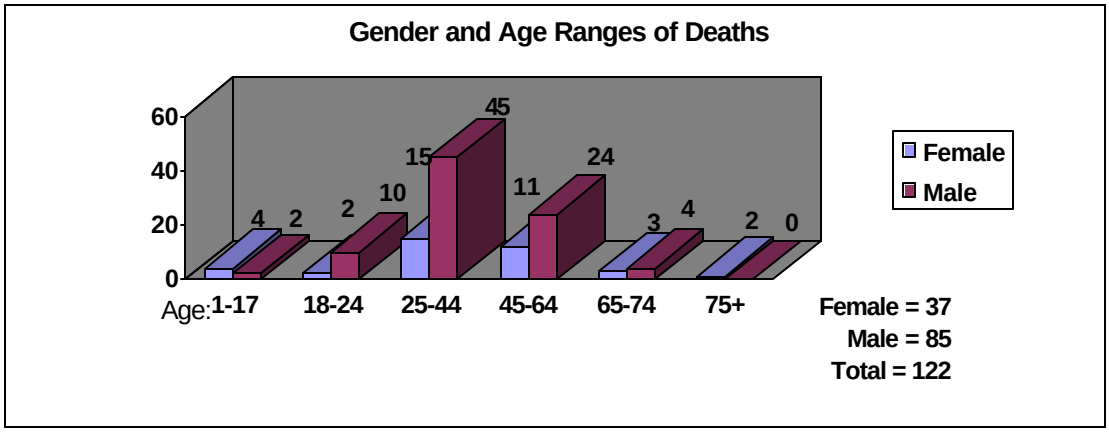


Table 1: Reportable deaths by type of program and cause of death. A comparison of data from 1997 through 2001.

PROGRAM	RESTRAINTS					SECLUSION					PSYCHOTROPIC MEDICATION					SUICIDE*					TOTALS
Year →	**'97**	**'98**	**'99**	**'00**	**'01**	**'97**	**'98**	**'99**	**'00**	**'01**	**'97**	**'98**	**'99**	**'00**	**'01**	**'97**	**'98**	**'99**	**'00**	**'01**	
Nursing Homes		1												1		1	1		1		**5 (1%)**
Mental Health Institutes																1			1	2	**4 (1%)**
Mental Health Inpatient																2	4	2	4	6	**18 (4%)**
AODA Inpatient																		1		2	**3 (<1%)**
ICFs-MR for DD																					
Centers for DD																					
CSP Programs	1 [1]										1 [2]			1		5	6 [3]	4	4	10	**32 (8%)**
MH Crisis Services																1	2		1	1	**5 (1%)**
MH Day Treatment																			1	3	**4 (1%)**
AODA Detox.																2			1		**3 (<1%)**
AODA Methadone												1 [5]						3			**4 (1%)**
RCCs				1													1				**2 (<1%)**
CBRFs														2		2	1	1	1	1	**8 (2%)**
AODA Day Treatment															1			1	2	3	**7 (2%)**
MH Outpatient															2	47	35 [4]	33	58	85	**260 (65%)**
AODA Outpatient																12	16	8	5	6	**47 (12%)**
TOTALS	**1**	**1**		**1**							**1**	**1**		**4**	**3**	**73**	**66**	**53**	**79**	**119**	**402**

CSP = Community Support Program; RCC = Residential Care Center for Children and Youth; CBRF = Community Based Residential Facility

See explanation of data with superscripts at the top of page 3

*See Suicide Data Analysis on page 3

Explanation of data with superscripts in Table 1.

1) This death, as reported by the CSP, resulted from the person being subdued by law enforcement personnel and handcuffed. While in custody he was found to be not breathing and was taken to a local hospital where he was placed on life support systems.

2) This death resulted from the individual ingesting a lethal amount of psychotropic medication. The coroner ruled the manner of death as accidental.

3) Includes 1 death reported by a CSP as a suicide which occurred in a jail

4) Includes 2 deaths reported by MH Outpatient programs as suicides which occurred in jails.

5) Cause of death was multi-drug toxicity. Manner of death was determined to be accidental.

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Suicide Data Analysis for CY 2001 Wisconsin Statutorily Reportable Deaths Reported to the Department of Health and Family Services

- Suicide deaths accounted for 119 (98%) of the 122 deaths reported to the Department. These individual deaths represent consumers of mental health, substance abuse and developmental disability services.

- Eighty-one percent of all suicides (96 out of 119) were adult men and women aged 25 to 64.

- Sixty percent of persons committing suicide (71 out of 119) occur in adult men aged 25 to 64.

- Males (85) are two and one-half times more likely to die from suicide than females (34).

- In the five years from 1997 to 2001, 390 consumers of services in Wisconsin died from suicide.

- Research estimates that for every suicide death there are six to eight significant others (family members and other survivors), who suffer the negative impact of suicide, often experiencing long-lasting consequences related to mental and physical well being, self esteem, and productivity. When considering only the statutorily reportable deaths for CY 2001, this represents potentially 952 men, women and children who have been assigned to the ranks of survivors of suicide.

- When the total number of suicides of Wisconsin residents annually is considered, the number of affected individuals is even higher. For 2001, 635 Wisconsin residents committed suicide. Applying the above-mentioned estimates, potentially 5,080 individuals are new survivors of suicide.

- Research estimates that for every suicide death there are five inpatient hospitalizations and 22 hospital emergency department visits for suicidal behavior every year – potentially 3,213 visits per year based on the CY 2001 statutorily reportable deaths by suicide (119).
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Table 2: Department actions taken in 2001 on reportable deaths by cause of death.

Type of Action	Restraints	Psychotropic Medication	Suicides
Citations of deficiency related to the incident			BQA = 1
Citations of deficiency not related to the incident			BQA = 5
Suspension or revocation of license/certification			
Technical assistance/consultation offered/provided			BCMH = 9
Policy and program changes			DCTF = 1
Referral to Department of Reg. & Licensing			
No further department action needed			106
TOTALS			**122**

BCMH = Bureau of Community Mental Health; BQA = Bureau of Quality Assurance;
DCTF = Division of Care and Treatment Facilities